CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

CHAPTER II
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CHAPTER II
PROVIDER PARTICIPATION REQUIREMENTS

PROVIDER QUALIFICATIONS

Provider Manuals and manual updates are posted on the DMAS website (www.dmas.virginia.gov) for viewing and downloading. Providers are notified of manual updates through messages posted on Medicaid remittance advices.

Inpatient Hospital

All Medicaid recipients may receive inpatient hospital psychiatric care in a general acute care hospital. Residents over the age of 65 may receive services in a freestanding psychiatric hospital. Individuals under the age of 21 enrolled in EPSDT may receive psychiatric services in a freestanding hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The facility must also meet state licensure requirements.

Residential Treatment

Individuals under the age of 21 in the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) may receive residential psychiatric care in:

1. A residential treatment program for children and adolescents licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) that is located in a psychiatric hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

2. A residential treatment program for children and adolescents licensed by DMHMRSAS that is located in a psychiatric unit of an acute general hospital accredited by the JCAHO; or

3. A psychiatric facility that is (i) accredited by JCAHO, the Commission on Accreditation of Rehabilitation Facilities, the Council on Quality and Leadership in Support for People with Disabilities, or the Council on Accreditation Services for Families and Children and (ii) licensed by DMHMRSAS as a residential treatment program for children and adolescents.

Treatment Foster Care Case Management

Treatment Foster Care Case Management shall be provided by child placing agencies with treatment foster care programs that are licensed or certified by the Virginia Department of Social Services (DSS) to be in compliance with DMAS and meet the provider qualifications for treatment foster care set forth in these regulations.

Providers may bill Medicaid for case management for children in treatment foster care only when the services are provided by qualified foster care case managers. The case manager must meet, at a minimum, the qualifications specified by DMAS.

Minimum Standards for Case Managers

a. A doctor's or master's degree in social work from a college or university accredited by the Council on Social Work Education or in a field related to social work such as sociology, psychology, education, or counseling, with a student placement in providing casework services to children and families. One year of experience in providing casework services to children and families may be substituted for a student placement; or

b. A baccalaureate degree in social work or a field related to social work including sociology, psychology, education, or counseling and one year of experience in providing casework services to children and families; or

c. A baccalaureate degree in any field plus two years' experience in providing casework services to children and families.

Enrolled Providers

Only facilities and licensed individuals enrolled as Medicaid providers may bill Medicaid for psychiatric services.

Provider Qualifications for Psychiatric Services

Psychiatric Services may be provided by:

- A psychiatrist who is a licensed physician who has completed at least three years of postgraduate residency training in psychiatry;
- A licensed clinical psychologist licensed by the Department of Health Professions, Board of Psychology;
- A licensed clinical social worker (LCSW) licensed by the Department of Health Professions, Board of Social Work;
- A licensed professional counselor (LPC) licensed by the Department of Health Professions, Board of Professional Counselors, Marriage and Family Therapists, and Substance Abuse Professionals; or
- A psychiatric clinical nurse specialist - Psychiatric (CNS) licensed by the Board of Nursing and certified by the American Nurses Credentialing Center.
- An individual who has completed his or her graduate degree and is under the direct personal supervision of an individual licensed under state law. The individual must be working towards licensure and supervised by the appropriate licensed professional in accordance with the requirements of the individual

profession.

Direct Supervision

When services are provided by an unlicensed individual, the provider must ensure that:

- The plan of care is approved and signed by the licensed professional. It must state the need for psychiatric treatment; the objectives or goals of the psychotherapy, which fall within the parameters of Medicaid-covered services, and be congruent with the diagnosis and initial evaluation of the client; and it must include a treatment regimen, projected schedule, and schedule for reevaluation. Documentation in the client's record should include written records of client contacts, services rendered, the role of the service to the care plan, and updates of the client's progress. The medical record must contain the notes that are countersigned or signed by the licensed individual to show that he or she personally reviewed the patient's medical history and confirmed the plan of care.

- Each psychotherapy session must be written at the time the service is rendered and must be signed and dated by the therapist rendering the service. If the therapy session is rendered by an unlicensed therapist, and under the direct, personal supervision of a qualified, Medicaid enrolled provider, the therapy session must contain not only the signature of the therapist rendering the service but also the signature of the supervising provider. Each therapy session must contain the co-signature of the supervising provider on the date the service was rendered indicating that he or she has reviewed the note.

- The licensed supervisor does not have to be present in the room during the session, but must be in the facility during the session and meet regularly with the professional to discuss the client's plan of care and review the record. The record should indicate that the patient's progress and plan of care are reviewed at least after every six sessions by the supervising licensed professional.

FREEDOM OF CHOICE

The patient shall have the right to choose to receive services from any Medicaid-enrolled provider of services. However, payments under the Medical Assistance Program are limited to providers who meet the provider participation standards and who have signed a written agreement with the Department of Medical Assistance Services.

REQUESTS FOR PARTICIPATION

To become a Medicaid provider of services, the provider must request a participation agreement by contacting:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

Telephone Numbers:

804-270-5105 (Local)
1-888-829-5373 (In state toll-free)
804-270-7027 (Fax)

PROVIDER ENROLLMENT

Each provider of services must be enrolled in the Medicaid Program prior to billing for any services provided to Medicaid recipients. All providers must sign a Medicaid Provider Agreement. The signature must be an original signature. An agreement for specific psychiatric services must be signed by the authorized agent of the provider. All providers must complete the participation agreement and return it to the Provider Enrollment and Certification unit of FIRST HEALTH (FH/PEU).

Upon receipt of the signed provider agreement and supporting documentation, a seven-digit provider number will be assigned to each approved provider. Provider identification numbers are specific to one location only. Providers must obtain separate provider identification numbers for each physical or servicing location where services are provided to Medicaid recipients. This number is to be used on all claims and correspondence submitted to Medicaid.

As part of the supporting documentation for a psychiatric residential treatment provider, DMAS must receive a signed letter of attestation from the Chief Executive Officer (CEO) of the facility stating that the facility is in compliance with the federal condition of participation of restraint and seclusion in psychiatric residential facilities (42 CFR §§ 483.350 – 483.376). If there is a change in CEOs, a new letter of attestation must be submitted.

Instructions for billing and specific details concerning the Medicaid Program are contained in this manual. Providers must comply with all sections of this manual to maintain continuous participation in the Medicaid Program.

PARTICIPATION REQUIREMENTS

Requirements for providers approved for participation include, but are not limited to, the following:

- Immediately notify FH/PEU, in writing, whenever there is a change in any of the information that the provider previously submitted.

- Ensure freedom of choice to recipients in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the required

service(s) and participating in the Medicaid Program at the time the service was performed;

- Ensure the recipient's freedom to reject medical care and treatment;
- Comply with Title VI of the Civil Rights Act of 1964, as amended, (42 U.S.C. §§ 2000d through 2000d-4a) which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the basis of race, color, or national origin;
- Provide services, goods, and supplies to recipients in full compliance with the requirements of the Rehabilitation Act of 1973, as amended, (29 U.S.C. § 794) which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities;
- Provide services and supplies to recipients of the same quality and in the same mode of delivery as provided to the general public;
- Charge DMAS for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public;
- Not require, as a precondition for admission, any period of private pay or a deposit from the patient or any other party;
- Accept Medicaid payment from the first day of eligibility if the provider was aware that an application for Medicaid eligibility was pending at the time of admission;
- Effective May 22, 2002, serious incidents must be reported to DMAS and DMHMRSAS. Serious incidents include a resident’s death, suicide attempt, or a serious injury that requires medical attention. In the case of injury, DMAS must be notified by fax to Contract Monitor at (804) 786-5799. The fax must include the following information:
    - Recipient’s name and Medicaid number;
    - Facility name and address of incident;
    - Names of staff involved;
    - Description of the incident;
    - Outcome, including the persons notified; and
    - Current location of the recipient.

- Accept as payment in full the amount established by DMAS to be reasonable cost or maximum allowable cost. 42 CFR § 447.15 states: "A State Plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amount paid by the agency." A provider may not bill a recipient for a covered service regardless of whether the provider received payment from the state. A provider may not seek to collect from a Medicaid recipient, or any financially responsible relative or representative of that recipient, any amount that exceeds the established Medicaid allowance for the service rendered. If a third-party payer reimburses $5.00 out of an $8.00 charge, and Medicaid's allowance is $5.00, then payment in full of the Medicaid allowance has been made. The provider may not attempt to collect the $3.00 difference from Medicaid, the recipient, a spouse, or a responsible relative. The provider may not charge DMAS or the recipient for broken or missed appointments;

- Reimburse the patient or any other party for any monies contributed toward the patient's care from the date of eligibility. The only exception is when a patient is spending down excess resources to meet eligibility requirements;

- Accept assignment of Medicare benefits for eligible Medicaid recipients;

- Use program-designated billing forms for submission of charges;

- Maintain and retain the business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided. In general, such records must be retained for a period of not less than five years from the date of service or as provided by applicable state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved (refer to the section on documentation of records);

- Furnish to authorized state and federal personnel access to records and facilities in the form and manner requested;

- Disclose, as requested by DMAS, all financial, beneficial ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of medical assistance; and

- Hold confidential and use for authorized DMAS purposes only all medical assistance information regarding recipients. A provider shall disclose information in his or her possession only when the information is to be used in conjunction with a claim for health benefits or when the data is necessary for the functioning of the state agency. The state agency shall not disclose medical information to the public.

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 of the Rehabilitation Act of 1973, as amended, (29 U.S.C. § 794) provides that no individual with a disability shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. Each Medicaid participating provider is responsible for making provisions for such disabled individuals in the provider's programs and activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. The provider's signature on the claim indicates compliance with the Rehabilitation Act.

In the event a discrimination complaint is lodged, DMAS is required to provide to the Office of Civil Rights (OCR) any evidence regarding non-compliance with these requirements.

UTILIZATION OF INSURANCE BENEFITS

The Virginia Medical Assistance Program is a "last pay" program. Benefits available under medical assistance shall be reduced to the extent that they are available through: other federal, state, or local programs; coverage provided under federal or state law; other insurance; or third party liability.

Health, hospital, workers' compensation, and accident insurance benefits shall be used to the fullest extent in meeting the medical needs of the covered person. Supplementation of available benefits shall be as follows:

- Title XVIII (Medicare) - Virginia Medicaid will pay the amount of any deductible or coinsurance up to the Medicaid limits for covered health care benefits under Title XVIII of the Social Security Act (42 U.S.C. §§ 1395 through 1395ggg) for all eligible persons covered by Medicare and Medicaid.

- Workers' Compensation - No Medicaid program payments shall be made for a patient covered by workers' compensation.

- Other Health Insurance - When a recipient has other health insurance (such as CHAMPUS, Blue Cross-Blue Shield, or Medicare), Medicaid requires that these benefits be used first. Supplementation shall be made by the Medicaid Program when necessary, but the combined total payment from all insurance shall not exceed the amount payable under Medicaid had there been no other insurance.

- Liability Insurance for Accidental Injuries - The Virginia Medicaid Program will seek repayment from any settlements or judgments in favor of Medicaid

recipients who receive medical care as the result of the negligence of another. If a recipient is treated as the result of an accident and the Virginia Medical Assistance Program is billed for this treatment, Medicaid should be notified promptly so action can be initiated by Medicaid to enforce any lien that may exist under § 8.01-66.9:1 of the Code of Virginia. In liability cases, providers may choose to bill the third party carrier or file a lien in lieu of billing Medicaid.

In the case of an accident in which there is a possibility of third-party liability or if the recipient reports a third-party responsibility (other than those cited on his or her Medical Assistance Identification Card), and regardless of whether or not Medicaid is billed by the provider for rendered services related to the accident, the psychiatric hospital is requested to forward the DMAS-1000 to the attention of the Third-Party Liability Unit, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219.

ASSIGNMENT OF BENEFITS

If a Virginia Medical Assistance Program beneficiary is the holder of an insurance policy which assigns benefits directly to the patient, the psychiatric hospital must require that benefits be assigned to the psychiatric hospital or refuse the request for the itemized bill that is necessary for the collection of the benefits.

USE OF RUBBER STAMPS FOR PHYSICIAN DOCUMENTATION

[Effective Date: January 23, 1992]

A required physician signature for Medicaid purposes may include signatures, written initials, computer entries, or rubber stamps initialed by the physician. However, these methods do not preclude other requirements that are not for Medicaid purposes. For more complete information, see the *Physician Manual* issued by DMAS.

FRAUD

Provider fraud is willful and intentional diversion, deceit, or misrepresentation of the truth by a provider or his or her agent to obtain or seek direct or indirect payment, gain, or items of value for services rendered or supposedly rendered to recipients under Medicaid. A provider participation agreement will be terminated or denied when a provider is found guilty of fraud.

Since payment of claims is made from both State and Federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either Federal or State Court. DMAS maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, United States Attorney General, or the appropriate law enforcement agency.

Further information about fraudulent claims is available in Chapter V, "Billing Instructions," and Chapter VI, "Utilization Review and Control" of this manual.

TERMINATION OF PROVIDER PARTICIPATION

The Participation Agreement will be time-limited with periodic renewals required. DMAS will request a renewal of the Participation Agreement prior to the expiration of the agreement.

A participating provider may terminate participation in Medicaid at any time; however, written notification of voluntary termination must be provided to FIRST HEALTH/Provider Enrollment Unit thirty (30) days prior to the effective date.

DMAS may terminate a provider from participation with thirty (30) days' written notification prior to the effective date. Such action precludes further payment by DMAS for services provided recipients subsequent to the date specified in the termination notice. Termination by DMAS shall be treated as an adverse action, and the provider shall be entitled to a reconsideration and/or hearing as identified below.

Any provider losing JCAHO accreditation will be notified of DMAS termination. DMAS can rescind the termination of the provider agreement if accreditation is restored; however, Medicaid reimbursement will not be available for any period during which the provider does not meet DMAS provider participation standards.

Section 32.1-325.D.2 of the Code of Virginia mandates that "Any such (Medicaid) agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify DMAS of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of state law.

RECONSIDERATION AND APPEALS OF ADVERSE ACTIONS

The following procedures will be available to all providers when DMAS takes adverse action. Adverse action for purposes of this section includes termination or suspension of the provider agreement and denial of payment for services rendered based on utilization review.

The reconsideration and appeals process will consist of three phases: a written response and reconsideration of the preliminary findings, the informal conference, and the formal evidentiary hearing. The provider will have 30 days to submit information for written reconsideration and will have 30 days' notice to request the informal conference and/or the formal evidentiary hearing.

An appeal of adverse actions concerning provider reimbursement shall be heard in

accordance with the Administrative Process Act (APA) (Section 2.2-4000, et seq.) and the *State Plan for Medical Assistance* provided for in Section 32.1-325 of the Code of Virginia. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the APA.

Any legal representative of a provider must be duly licensed to practice law in the Commonwealth of Virginia.

Repayment of Identified Overpayments

Pursuant to Section 32.1-325.1 of the Code of Virginia, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When a lump sum cash payment is not made, interest will be added on the declining balance at the statutory rate, pursuant to Section 32.1-313.1 of the Code of Virginia. Repayment and interest will not apply pending appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates to the satisfaction of DMAS a financial hardship warranting extended repayment terms.

EXHIBITS

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DO NOT WRITE IN SHADED AREAS. DO NOT ADD CONDITIONS TO THE AGREEMENT. WE DO NOT ACCEPT AGREEMENTS VIA FAX OR AGREEMENTS ON THERMAL PAPER.

Commonwealth of Virginia
Department of Medical Assistance Services
Medical Assistance Program

Hospital Participation Agreement

If re-enrolling, enter **Medicaid** Provider Number here→ _____ Check this box if requesting new number→ ☐

Enter 6-digit **MEDICARE** provider number here→ _____ Check this box if Rehab Hospital→ ☐

This is to certify:	PAYMENT/CORRESPONDENCE ADDRESS	PHYSICAL ADDRESS (*REQUIRED IF DIFFERENT FROM PAYMENT ADDRESS*)
NAME		
ATTENTION		
ADDR LINE 1		
ADDR LINE 2		
CITY, STATE, ZIP		

on this _____day of _____ , _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

1. The provider is currently licensed and certified under applicable laws of this state. (Check the item which applies to your hospital.)

   ____ A.) As of _____ (Date) has been fully certified for participation with Title XVIII (Medicare)of Public Law 89-97.

   ____ B.) Is limited to an age group not eligible for Title XVIII benefits, but is as of _____ (Date), accredited by the Joint Commission on Accreditation for Hospitals and has a utilization review plan which meets Title XVIII AND Title XIX standards for utilization review.
2. Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his medical or physical handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in accordance with the terms of Section 504 of the Rehabilitation Act of 1973 (29 U.S.C.§ 794) in VMAP.
3. The applicant agrees to keep such records as VMAP determines necessary. The applicant will furnish VMAP, on request, information regarding payments claimed for providing services under the state plan. Access to records and facilities by authorized VMAP representatives, the Attorney General, or his authorized representatives, and authorized federal personnel will be permitted upon reasonable request.
4. The applicant agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.
5. Payment made by VMAP constitutes full payment except for patient pay amounts determined by VMAP, and the applicant agrees not to submit additional charges to the recipient for services covered under Medicaid. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a Medicaid recipient for any service provided under Medicaid is expressly prohibited and may subject the provider to federal or state prosecution.
6. The applicant agrees to pursue all other available third party payment sources prior to submitting a claim to VMAP.
7. Payment by VMAP at its established rates for the services involved shall constitute full payment to the provider. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.
8. The applicant agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended.
9. This agreement may be terminated at will on 30 (thirty) days' written notice by either party or by VMAP when the provider is no longer eligible to participate in the program.
10. All disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.
11. This agreement shall commence on _____ and terminate on _____.

For First Health's use *only*

Director, Division of Program Operations Date

IRS Name (required)

mail one completed original agreement to: First Health - VMAP-Provider Enrollment Unit
4461 Cox Rd. Suite 102
Glen Allen, VA 23060-3331

For Provider of Services:

Original Signature of Administrator Date

Title

____City OR ____County of _____

IRS Identification Number (Area Code) Telephone Number

Medicare Carrier and Vendor Number (if applicable)

DO NOT WRITE IN SHADED AREAS. DO NOT ADD CONDITIONS TO THE AGREEMENT. WE DO NOT ACCEPT AGREEMENTS VIA FAX OR AGREEMENTS ON THERMAL PAPER.

Commonwealth of Virginia
Department of Medical Assistance Services
Medical Assistance Program

Psychiatric Treatment Hospital

Early Periodic Screening, Diangosis and Treatment Program (EPSDT) Participation Agreement

If re-enrolling, enter **Medicaid** Provider Number here→ _____ Check this box if requesting new number→ ☐

Enter 6-digit **MEDICARE** provider number here→ _____

This is to certify:	PAYMENT/CORRESPONDENCE ADDRESS	PHYSICAL ADDRESS (*REQUIRED IF DIFFERENT FROM PAYMENT ADDRESS*)
NAME		
ATTENTION		
ADDR LINE 1		
ADDR LINE 2		
CITY, STATE, ZIP		

on this _____day of _____ , _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

1. **The provider is a psychiatric hospital accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) and meets all the requirements in 42 CFR 441, Subpart D.**
2. **Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his medical or physical handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in accordance with the terms of Section 504 of the Rehabilitation Act of 1973 (29 U.S.C.§ 794) in DMAS.**
3. **The applicant agrees to keep such records as DMAS determines necessary. The applicant will furnish DMAS, on request, information regarding payments claimed for providing services under the state plan. Access to records and facilities by authorized DMAS representatives, the Attorney General, or his authorized representatives, and authorized federal personnel will be permitted upon reasonable request.**
4. **The provider agrees to care for patients at the DMAS rate as of the date the service is rendered, which is an all-inclusive fee including but not limited to physician care and medications.**
5. **Payment made by DMAS at its established rates constitutes full payment except for patient pay amounts determined by DMAS, and the applicant agrees not to submit additional charges to the recipient for services covered under Medicaid. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a Medicaid recipient for any service provided under Medicaid is expressly prohibited and may subject the provider to federal or state prosecution. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by DMAS, the provider will reimburse DMAS upon demand.**
6. **The applicant agrees to pursue all other available third party payment sources prior to submitting a claim to DMAS.**
7. **The applicant agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of DMAS as from time to time amended.**
8. **This agreement may be terminated at will on 30 (thirty) days' written notice by either party or by DMAS when the provider is no longer eligible to participate in the Program.**
9. **All disputes regarding provider reimbursement and/or termination of this agreement by DMAS for any reason shall be resolved through administrative proceedings conducted at the office of DMAS in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.**

10. This agreement shall commence on _____ and terminate on _____.

For First Health's use *only*

Director, Division of Program Operations Date

IRS Name (required)

mail **one** completed **original** agreement to: **First Health - VMAP-Provider Enrollment Unit 4461 Cox Rd. Suite 102 Glen Allen, VA 23060-3331**

For Provider of Services:

Original Signature of Provider **Date**

Title

____City OR ____County of _____

IRS Identification Number **(Area Code) Telephone Number**

Medicare Carrier and Vendor Number (if applicable)

COMMONWEALTH OF VIRGINIA
Department of Medical Assistance Services
Medical Assistance Program

Residential Psychiatric Treatment for Children and Adolescents

If re-enrolling, enter **Medicaid** Provider Number here→ _____ Check this box if requesting new number→ ☐

This is to certify:

	PAYMENT/CORRESPONDENCE ADDRESS	**PHYSICAL ADDRESS** (***REQUIRED IF DIFFERENT FROM PAYMENT ADDRESS***)
NAME		
ATTENTION		
ADDR LINE 1		
ADDR LINE 2		
CITY, STATE, ZIP		

on this _____ day of _____ , _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

Enter 6-digit **MEDICARE** provider number here→ _____

1. **The provider is a psychiatric entity licensed by DMHMRSAS as a Residential Treatment Program and accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) OR Council on Accreditation of Services for Families and Children OR the Commission on Accreditation of Rehabilitation Facilities and meets all the requirements in 42 CFR 441, Subpart D.**
2. **Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his medical or physical handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in accordance with the terms of Section 504 of the Rehabilitation Act of 1973 (29 U.S.C.§ 794) in DMAS.**
3. **The applicant agrees to keep such records as DMAS determines necessary. The applicant will furnish DMAS, on request, information regarding payments claimed for providing services under the state plan. Access to records and facilities by authorized DMAS representatives, the Attorney General, or his authorized representatives, and authorized federal personnel will be permitted upon reasonable request.**
4. **The provider agrees to care for patients at the lessor of the rate established by the Community Planning and Management Team or the current maximum rate established for the facility by VMAP at the date of service.**
5. **Payment made by DMAS at its established rates constitutes full payment except for patient pay amounts determined by DSS and the applicant agrees not to submit additional charges to the recipient for services covered under Medicaid. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a Medicaid recipient for any service provided under Medicaid is expressly prohibited and may subject the provider to federal or state prosecution. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by DMAS, the provider will reimburse DMAS upon demand.**
6. **The applicant agrees to pursue all other available third party payment sources prior to submitting a claim to DMAS.**
7. **The applicant agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of DMAS as from time to time amended.**
8. **This agreement may be terminated at will on 30 (thirty) days' written notice by either party or by DMAS when the provider is no longer eligible to participate in the Program.**
9. **All disputes regarding provider reimbursement and/or termination of this agreement by DMAS for any reason shall be resolved through administrative proceedings conducted at the office of DMAS in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.**

10. **This agreement shall commence on _____. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.**

For First Health's use *only*

For Provider of Services:

Original Signature of Provider **Date**

Title

Director, Division of Program Operations Date

IRS Name (required)

mail **one** completed **original** agreement to:

First Health - VMAP-Provider Enrollment Unit
PO Box 26803
Richmond, Virginia 23261-6803

_____City OR _____County of

IRS Identification Number **(Area Code) Telephone Number**

Medicare Carrier and Vendor Number (if applicable)

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
Medical Assistance Program

Treatment Foster Care Case Management Agreement

If re-enrolling, enter Medicaid Provider Number here→ _____ Check this box if requesting new number→ ☐

This is to certify:	**PAYMENT/CORRESPONDENCE ADDRESS**	**PHYSICAL ADDRESS (*REQUIRED IF DIFFERENT FROM PAYMENT ADDRESS*)**
NAME		
ATTENTION		
ADDR LINE 1		
ADDR LINE 2		
CITY, STATE, ZIP		

on this _____ day of _____ , _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

1. **The provider will provide Treatment Foster Care Case Management Services .**
2. **Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. In accordance with the terms of Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794,) no handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in VMAP.**
3. **The provider agrees to keep such records as VMAP determines necessary. The provider will furnish VMAP on request information regarding payments claimed for providing services under the State Plan. Access to records and facilities by authorized VMAP representatives and the Attorney General of Virginia or his authorized representatives, and authorized federal personnel will be permitted upon reasonable request.**
4. **The provider agrees to care for patients at the lessor of the rate established by the Community Planning and Management Team or the current maximum rate established by VMAP as of the date of service.**
5. **Payment made under VMAP constitutes full payment for treatment foster care case management on behalf of the recipient except for patient pay amounts determined by DSS, and the provider agrees not to submit additional charges to the recipient or the Community Planning and Management Team for treatment foster care case management services covered under VMAP. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a VMAP recipient for any service provided under VMAP is expressly prohibited and may subject the provider to federal or state prosecution.**
6. **The provider agrees to pursue all other health care resources of payment prior to submitting a claim to VMAP.**
7. **Payment by VMAP at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider shall reimburse VMAP upon demand.**
8. **The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended.**
9. **This agreement may be terminated at will on thirty days' written notice by either party or by VMAP when the provider is no longer eligible to participate in the program.**
10. **All disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.**
11. **The provider agrees, at all times, to retain full responsibility for any and all performance under this agreement, whether performed by the provider or others under contract to the provider.**

12. **This agreement shall commence on _____. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.**

For Provider of Services:

Original Signature of Provider **Date**

Title

_____City OR _____County of _____

For First Health's use *only*

Director, Division of Program Operations Date

IRS Name (Required)		IRS Identification Number	(Area Code) Telephone Number
mail **one** completed **original** agreement to:	**First Health - VMAP-Provider Enrollment Unit** PO Box 26803 **Richmond, Virginia 23261-6803**		

Commonwealth of Virginia
Department of Medical Assistance Services
Medical Assistance Program

Participation Agreement

If re-enrolling, enter Medicaid Provider Number here→ _____ Check this box if requesting new number→ ☐

☐ If you wish to be a MEDALLION PCP, check this box. The MEDALLION provider enrollment form must be attached.
☐ If you are already a MEDALLION provider, check this box.

This is to certify:	PAYMENT/CORRESPONDENCE ADDRESS	PHYSICAL ADDRESS (*REQUIRED IF DIFFERENT FROM PAYMENT ADDRESS*)
INDIVIDUAL PROVIDER NAME		
ATTENTION		
ADDR LINE 1		
ADDR LINE 2		
CITY, STATE, ZIP		

on this _____ day of _____, _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

1. The provider is authorized to practice under the laws of the state in which he is licensed and practicing and is not as a matter of state or federal law disqualified from participating in the Program.
2. Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of l973 29 USC.794) VMAP.
3. The provider agrees to keep such records as VMAP determines necessary. The provider will furnish VMAP on request information regarding payments claimed for providing services under the State Plan. Access to records and facilities by authorized VMAP representatives and the Attorney General of Virginia or his authorized representatives, and federal personnel will be permitted upon reasonable request.
4. The provider agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.
5. Payment made by VMAP constitutes full payment except for patient pay amounts determined by VMAP, and the provider agrees not to submit additional charges to the recipient for services covered under VMAP. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a medical assistance recipient for any service provided under medical assistance is expressly prohibited.
6. The provider agrees to pursue all other available third party payment sources prior to submitting a claim to VMAP.
7. Payment by VMAP at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.
8. The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended.
9. This agreement may be terminated at will on thirty days' written notice by either party or by VMAP when the provider is no longer eligible to participate in the Program.
10. All disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.
11. If qualified to be a Primary Care Provider, the applicant agrees to comply with all applicable MEDALLION state and federal laws, administrative policies and procedures of DMAS, and the requirements identified in Appendix A as from time to time amended.
12. This agreement shall commence on _____ and terminate on _____.

For First Health's use *only*

Director, Division of Program Operations Date

IRS Identification Name (Required)
mail one completed original agreement to: First Health - VMAP-Provider Enrollment Unit
4461 Cox Rd. Suite 102
Glen Allen, VA 23060-3331

For Provider of Services:

Original Signature of Provider Date

Provider Specialty

____City OR ____County of _____

Board License Number (Area Code) Telephone Number

IRS Identification Number (Required) UPIN

Medicare Carrier and Vendor Number

Commonwealth of Virginia
Department of Medical Assistance Services
Medical Assistance Program

APPENDIX A
MEDALLION PROVIDER REQUIREMENTS

Medicaid enrolled physicians with a specialty of obstetrics/gynecology, general/family practice, pediatrics, internal medicine, or other specialties approved by the Department of Medical Assistance Services. Qualified Health Department Clinics, Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) may be MEDALLION primary care providers (PCP). The MEDALLION PCP agrees to the following:

1. Function in the role of PCP for MEDALLION. In this role, the Provider will carry out all routine preventative and treatment services to MEDALLION patients assigned to the PCP's practice. This will include Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services and maintenance of a comprehensive medical record for each patient assigned to the PCP's MEDALLION panel. In particular, the PCP will provide and/or coordinate patient management for all preventive, primary and specialty health care services. The PCP must have admitting privileges at a local accredited hospital or must make arrangements for admissions with a physician who does have admitting privileges.

2. Make available 24-hour, 7 days per week access by telephone to a live voice (an employee of the PCP or an answering service) or an answering machine which will immediately page an on-call medical professional so that referrals can be made for non-emergency services or so information can be given about accessing services or how to handle medical problems during non-office hours.

3. Coordinate all other Medicaid authorized care for each patient enrolled in his or her MEDALLION caseload including referral to specialty providers for medically necessary services. In referring for specialized evaluation and/or treatment, the PCP will provide the specialist with authorization to cover appropriate testing and treatment. This authorization may be verbal or written for a period appropriate to the illness. The PCP will document all referrals in the patient's medical record.

4. The PCP will not restrict patient access to services exempt from MEDALLION referral requirements as specified by DMAS as exempted services which includes family planning, emergency services, obstetrical, and gynecological services.

5. Complete a BabyCare risk screen on every MEDALLION patient assigned to the PCP's panel who is eligible to receive a risk screen. If the patient is determined to be at risk and eligible to receive BabyCare services, the PCP must either provide BabyCare services (if the PCP is an enrolled BabyCare Provider) or refer the eligible patient to a Medicaid enrolled BabyCare Provider.

6. Enroll and participate in the Commonwealth of Virginia's Vaccines for Children (VFC) Program.

7. Provide case management, primary care and health education to enrollees that fosters continuity of care and improved provider/patient relationships.

8. Not refuse an assignment or disenroll a patient or otherwise discriminate against a patient solely on the basis of age, sex, race, physical or mental handicap, national origin, or type of illness or condition, except when that illness or condition can be better treated by another provider.

9. The PCP may request reassignment of a MEDALLION patient to another PCP, if the patient/PCP relationship is not mutually acceptable, patient's condition or illness would be better treated by another PCP or other reasons approved by DMAS. The PCP must notify the patient in a direct and timely manner of the PCP's desire to remove the patient from their caseload and keep the patient in the PCP's panel until another PCP is assigned or until the patient has been disenrolled from MEDALLION.

10. Providers will receive the usual Medicaid fees for services rendered (physician will also receive a monthly case management fee for each client assigned).

11. The PCP's Medicaid Provider Number will be used as the MEDALLION identification number.

12. In the event, the PCP fails to comply with these provisions, appropriate sanctions, up to and including termination from participation as a MEDALLION PCP, will be applied by DMAS. See paragraph (10) of the Medicaid Participation Agreement with respect to appeals, and the MEDALLION supplement to the Physician's Provider Manual with respect to sanctions.

13. The requirements outlined in this appendix will expire concurrent with any termination or expiration of the Provider Participation Agreement. However, these requirements may be terminated for any reason on thirty (30) days notice by either party without mandatory termination of the Agreement.